STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE & ADMINISTRATION
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TennCare Overview

On January 1, 1994, Tennessee began a new health care reform program called TennCare. This program, which required no new taxes, essentially replaced the Medicaid program in Tennessee. TennCare was designed as a managed care model. It extended coverage to uninsured and uninsurable persons who were not eligible for Medicaid.

The TennCare program was implemented as a five-year demonstration program approved by the federal Health Care Financing Administration (HCFA), which is now known as the Centers for Medicare and Medicaid Services (CMS). The program received several extensions after the original expiration date of December 30, 1999. In July 2002, Tennessee began a new five-year TennCare demonstration program.

The current TennCare program is really two programs. There is TennCare Medicaid, which is for persons who are Medicaid eligible, and TennCare Standard, which is for persons who are not Medicaid eligible but who have been determined to meet the state's criteria as being either uninsured or uninsurable. Historically, individuals in both programs have received the same services. TennCare Standard enrollees with family incomes at or above poverty are required to pay premiums and copays, however.

New reforms to TennCare were approved by CMS in the spring of 2005. According to these reforms, TennCare Standard adults aged 19 and over were to be disenrolled from the program, beginning in August 2005. TennCare Medically Needy adults aged 21 and older who were not pregnant were to be disenrolled also.

TennCare services are offered through several managed care entities. Each enrollee has a Managed Care Organization (MCO) for his primary care and medical/surgical services, a Behavioral Health Organization (BHO) for his mental health and substance abuse treatment services, and a Pharmacy Benefits Manager (PBM) for his pharmacy services. Children under the age of 21 are eligible for dental services, which are provided by a Dental Benefits Manager (DBM). Enrollees are allowed to choose the MCO they wish from among those available in the areas in which they live.

Traditionally, MCOs have been “at risk,” meaning that their compensation was based on a per member, per month capitation fee for each enrollee, regardless of how many services the enrollee used. However, because of instability among some of the MCOs participating in TennCare, the “at risk” concept was replaced in July 2002 with an “Administrative Services Only” (ASO) arrangement. MCOs began submitting invoices to TennCare for payment of medical services delivered and receiving a fixed administrative fee. The state added its own MCO, called TennCare Select, to serve as a backup if other plans failed or there was inadequate MCO capacity in any area of the state. TennCare Select is administered by BlueCross/BlueShield of Tennessee.

In addition to the TennCare managed care programs, the Bureau of TennCare administers certain long-term care services. These include care in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), as well as several Home and Community Based Services (HCBS) waiver programs which serve as alternatives to long-term care. The Bureau also handles Medicare cost-sharing payments for eligible individuals.